

Occupational therapy student's fieldwork placement: Institutional and community based rehabilitation models in the Solomon Islands.

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Abstract

Prior to the first permanent indigenous occupational therapist in the Solomon Islands setting up practice, two Australian students on a fieldwork placement were involved in helping to develop occupational therapy services. Services were delivered within existing institutional and community based rehabilitation models. This article describes the student's experiences and reflections on programme development and delivery. The reflections may assist occupational therapists and other students involved in similar ventures to address this large and varied area of practice. The project has significance for the professions intention to advance community based rehabilitation services to people living under adverse conditions in poorly resourced communities.

Key words

Occupational therapy; community based rehabilitation; student fieldwork.

Reference

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Occupational therapists are concerned with the health and well being of people challenged by adversity within any community. Adversity can take many forms such as: disease, disability, societal rejection due to religion, poverty, adversive governments, war, natural disasters, persistent and unyielding weather conditions and many others. Occupational therapists work with disadvantaged communities in wealthy developed nations as well as in poorly developed countries around the world (World Federation of Occupational Therapists, 2004).

Thibeault (2006) introduced the profession to the term 'majority world' referring to the nations of the world that are unable, or unwilling to adequately sustain a healthy lifestyle for all people living therein. The majority world lives with inequity and a lack of services in the field of health, education, human services and basic infrastructure. Thibeault highlighted social justice, equity of resources and individualized meaning within occupations, as core values within the profession. Such values serve occupational therapists well as they expand service provision to non-traditional settings, marginalized populations and communities in the majority world. Communication about cross cultural work experiences in disaster regions, developing and marginalized communities where people experience occupational apartheid, injustice and deprivation is growing (Kronenberg, Salvador, & Pollard, 2005).

This paper describes the first hand experience of an occupational therapy student who, with another student, completed a 10 week fieldwork placement in Honiara, Solomon Islands. The

placement was the final fieldwork requirement of the four year Bachelors in Health Science in Occupational Therapy, at La Trobe University, Melbourne Australia. At the time of this placement, physiotherapy was well established within the local hospital in Honiara, and provided on site supervision for the occupational therapy students. Supervision by an occupational therapist was not an option because although the first indigenous occupational therapist had completed her training in New Zealand and returned to the region, she had to wait for an official start date from the Government before commencing paid employment. The occupational therapist started work six weeks into the student's placement following official confirmation of employment.

A faculty member at La Trobe Univeristy (second author) provided distance supervision via email. Because it was the final year of study, the student was expected to extend her

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knowledge and skills through preset, self directed goals in a contractual agreement with her supervisor. A description of both institutional and community based rehabilitation (IBR and CBR respectively) is given because the student contributed to provision of occupational therapy service within these two models. An overview of the differences between Australia and Solomon Islands will also be presented to contextualize the cross cultural exchange between the student and local people involved in the project.

Majority world: Health and rehabilitation strategies

The World Health Organization (WHO) estimates that less than 5% of the world's 480 million people living with a disability have access to medical and rehabilitation services (WHO, 2005b). Consequently, the WHO promotes the right to equal opportunity and the active participation of people with disabilities within their communities, and acknowledges the relationships between health, disability and poverty (WHO, 2004). Community based rehabilitation (CBR) is a WHO community development strategy that seeks to equalize opportunities for people living with a disability. The goals and philosophy of CBR are compatible with the values, goals and philosophy of the occupational therapy profession (Fransen, 2005; WFOT, 2004).

CBR seeks to provide access to community benefits such as work and education, increase availability of rehabilitation and health services, and improve the overall social inclusion of people with disabilities (WHO, 2004). The objective is to facilitate change at an organizational level; community level, (including altering physical and attitudinal barriers); and to improve or make available, rehabilitation services and services that facilitate the full community participation of all people. CBR workers are locals who directly work with their community members to facilitate the goals of CBR. Health professionals both work with, and train, CBR workers and have an important role in facilitating achievement of CBR objectives (WHO, 2004).

The impact of CBR programmes on the quality of life for service recipients has been researched using a qualitative methodology (WHO, 2002). This research found that CBR positively impacts on the recipient's self-esteem; feelings of empowerment and influence; self reliance; and social inclusion. Further, the initiatives identified as being of the highest priority and most useful for persons with disabilities were firstly, "social counselling" and secondly, "training in mobility and daily living skills" (WHO, 2002, p.8). Such findings demonstrate that the occupational therapy profession has much to contribute to the development of CBR programmes.

CBR and IBR had been operating in

the Solomon Islands since 1988, when an Australian led group of allied health workers, including an occupational therapist and a physiotherapist, were invited to give a workshop by the national Disabled Persons Association. Subsequently, the CBR unit was established in the early 1990s and a physiotherapist was appointed national coordinator. The CBR unit recruited local people to be CBR aides, and to undertake a one year course in CBR. Further workshops to train CBR aides occurred on an ad hoc basis. The aides were mainly supervised by nurses.

The CBR unit is managed by the Ministry of Health and coordinates all services for the disabled in the community. It provides community based rehabilitation aides to work in the provinces to enable people with disabilities to have access to rehabilitation services. Staff from the CBR unit also undertakes community development work in their local area to improve quality of life for people with disabilities. In 2005, the national co-ordinator of CBR contacted the occupational therapist who assisted with the introduction of CBR, seeking a consultancy to design a 2 year occupational therapy programme accredited by the Solomon Island College of Higher Education for CBR aides. Part of the consultancy was the recruitment of occupational therapists to teach the accreditation course which began in 2006.

Another model of service provision utilized in developing communities is institutional based rehabilitation (IBR). This model more closely resembles western ideas of rehabilitation. Physiotherapy is an established department in a hospital within the IBR model. The likely absence of specialized personnel such as occupational therapists however means that "special efforts are needed to train local health personnel and family members to perform some of the tasks of the various rehabilitation professionals" (WHO, 2005a, p. 2). One drawback of IBR is that the western model on which it is based may be incompatible with local culture. Establishing occupational therapy services with an IBR model alone can be particularly challenging, even when a physiotherapy department already exists (Bourke-Taylor, 2006; Bourke-Taylor & Hudson, 2005).

Table 1: Brief comparison: Solomon Islands and Australia (National Geographical Society, 2008)

Items of comparison	Solomon Islands	Australia
Population	472,000	20,351,000
Official languages	Melanesian pidgin, 120 indigenous languages, English	English, Indigenous languages, various immigrant languages
Rate of unemployment	More than 80% of Solomon islanders live outside the cash economy	4.8%
Literacy percent (estimated)	62	99
Life expectancy (yrs)	71	80
Gross domestic product per capita	US\$1,700	US\$26,900

The Solomon Islands: Description of the setting

The Solomon Islands have existed under considerable political turmoil, including violent conflicts for some time. Australian and New Zealand peace keeping forces have been present in the Islands since 2003. Violent conflicts in 1998, and again in 2005 severely disturbed the economy and community infrastructure. Many people lost personal property, homes, businesses, and opportunities for paid employment. In April, 2007 an earthquake and tsunami struck the Solomons some 90 miles from the capital Honiara. Fifty-two people were killed and hundreds displaced. Subsequently, relief agencies have had an ongoing presence in the region to address issues such as the provision of shelter and education.

Even prior to the tsunami, the Solomon Islands were considered the poorest Pacific island nation as a result of social and political unrest (Gordon, 2006). Accurate facts about disease, mortality and disability are limited. Infectious disease such as malaria, tuberculosis and meningitis are common. The mortality rate for children under 5 years is 9 times higher than Australian children (WHO, 2006b). The ratio of physicians to the rest of the population is approximately 1:769 in the Solomons and 1:404 in Australia (WHO, 2006a). Table 1 compares statistics from the Solomon Islands and Australia using global benchmarks to provide the reader with an idea of the contrast between the lives of the student and the recipients of service. The reader is reminded that the selected source for this information was deemed reliable, although the potential for minor inaccuracies is acknowledged.

Student placement experience

The following account is by the first author of this paper.

In 2004, my classmate and I decided to pursue our final fieldwork placement in a hospital and CBR department in the Solomon Islands. Prior to leaving for the islands we prepared ourselves by researching dress codes, indigenous customs, health considerations including what inoculations were required and the local pidgin dialect. In addition, we established guidelines for ethical considerations, distance supervision and safety issues. Although we attempted to complete a needs analysis of the clients we would work with, there was a paucity of up to date information available.

Socio-cultural differences

On arrival in the Solomon's we were challenged by common morbidities and mortalities; the local perception of medical conditions; organisational

issues affecting service implementation; and resource needs. Our needs assessment only took shape in a realistic sense once we actually started work. In relation to the therapeutic programme we wanted to implement we had planned to become familiar with the culture, language and occupations by spending time with local people before starting our placement. Many customs and habits were new to us and we had to adapt to those. Examples included, men holding hands while walking down the road, greetings and directions given via eyebrow communication, signalling a bus to stop by hissing and bright crimson smiles because teeth, gums and lips were stained red from chewing the local, mildly narcotic beetle nut. Many daily occupations, that were also new to us, were performed in novel ways or valued in an unexpected manner. Examples of the differences are included in Table 2.

Honiara, the city where we were situated was approached by a tarmacked road dotted with potholes. Building regulations for universal access including use of ramps or hand rails was nonexistent. Most of the buildings were one or two storied and accommodation varied, with large extended families living in western style houses, tin shacks or picturesque huts on poles. People reacted to us with curiosity and friendship. Many would stop us and ask to 'story' (tell about ourselves). In rural areas the sight of a white young woman was rare, and often people would call out a greeting waving furiously with their machete. The stifling heat made physical activity strenuous.

Table 2: Examples of Solomon Island occupations, customs, and performance.

Occupation	Examples	Customs / performance / tools and tool use
Productive	Gardening	Machetes as multipurpose tools.
	Fishing	Traditional dug out canoes with paddles.
	Produce marketing	Open air markets, small subsistence produces.
	Craft	Different provinces have specific craft expertise.
Self care	Caring for 'stacka pikini' (many children)	Shared by all family members. A child chosen by the family may become the 'maidservant'.
	Toileting	Long drops, the sea or the bush.
	Personal ADL's 'swim swim'	Locations included: the sea, rivers, the pump or public taps with buckets.
	Cooking 'kaikai' and eating	Cooking by open fire, underground 'motus' or ovens made from barrels. Food often eaten outside.
Leisure	Toe nails	Toe nails are cut with a machete
	'Storying' or conversation	Hold hands while conversing. People invited and thanked for 'storying'.
	Soccer and volley ball	Most villages have their own soccer fields and volleyball areas. People with disabilities often excluded from active sport.
	Music and dance	Style of dance and music varied between tribes.

Service provision

Our first impression of the hospital was daunting. Located by the beach, it comprised of single storey buildings connected by walkways. Equipment was limited and the facilities often overcrowded. Relatives who came to visit people who had no ‘wantok’ (family) in the city, stayed in the hospital room. The beach was used as a dump for hospital refuse.

Our physiotherapy colleagues had limited knowledge of the skills occupational therapy students could offer but they were excited to have ‘splint makers’. Some of the physiotherapists had been trained in Australia and some in Fiji, others were trained on the job. As previously mentioned, the country’s first paid occupational therapist started work six weeks into the placement. She was an indigenous Solomon Islander, who had trained in New Zealand. Her education had been financed by the Solomon Island Government. On completion of her degree she had to wait 10 months for them to decide her future employment.

Aside from the health professionals already mentioned, staffing was limited to the CBR aides. These local workers were not trained in any specific allied health discipline. Accountability in terms of time management, professional protocols, gathering and documenting client information was limited in both CBR and IBR workplaces. For instance, documentation and accountability for a CBR aide could consist solely of a letter written to their department head explaining what they had done the past month.

Service needs

People with disabilities faced poverty, discrimination and physical environmental barriers limiting their participation in occupations. A lack of general health knowledge and limited schooling caused minor problems to develop into major impairments. Many islands had no immediate access to health professionals. People came to the hospital sometimes one year post injury. As a result, conditions such as a dislocated hip required lengthy admissions. Strong family ties in the ‘wantok’ system ensured family members with a disability were cared for. Tailored services were limited or unavailable and so often people with a disability did little for themselves. For example, children with cerebral palsy (CP) could be left lying on their back, on a mat, all day as family fed and cleaned them but provided few activities. Thus, family interdependence inadvertently promoted pressure sores, deformity, contractures and underdeveloped cognitive and emotional skills.

Student’s occupational therapy programme

After considering the above needs we set about developing a programme. A week consisted of two days in the hospital (IBR) and 3 days in the community with the local CBR aides visiting local homes.

Within the hospital, sports and garden groups were organised for clients with various impairments, such as upper or lower limb amputation; acquired brain injury; burns; and musculoskeletal injuries mainly related to machete cuts. Self care and domestic activities of daily living groups were also facilitated. In the community, developmental groups were run for children with CP within the local Red Cross facility. We visited clients in their home to address issues such as pressure care; inclusion of children with disabilities in family routines; incorporating appropriate play ideas for children with developmental delay into daily routines; and assisting adults with hemiplegia, or other physical disabilities to learn ways to dress and care for themselves. These CBR home visits introduced us to various levels of poverty and a range of living conditions. The terrain covered, the local housing conditions of more affluent clients, and the appropriate dress for the region is illustrated in Figure 1.

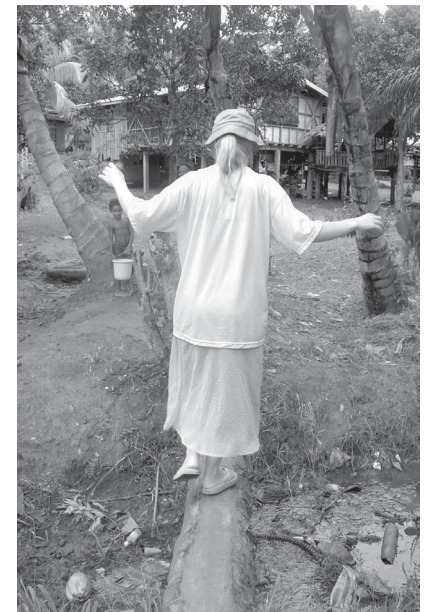


Figure 1

Reflections

Formal evaluation of the student led occupational therapy programmes was not undertaken. Nonetheless the student’s reflections are described in this section.

Several factors that might have improved our performance and university supervision of this placement became apparent only after the project had begun. Prior to leaving for the Solomon Islands research into the health needs of the people living there, revealed little information about the types of conditions and

Table 3: Occupation focused interventions

Obstacles	Strategies	Outcomes
‘Wantok’ cared for clients when client capable and interested in self care.	Endeavoured to educate clients and ‘wantok’ on the relationship between health and participation in daily activities.	Mixed responses. Interest in learning to be independent limited to young or newly disabled persons.
Negative attitudes limited client participation in occupations.	Sports and gardening groups initiated to facilitate client empowerment.	Clients enjoyed participating and began to ignore negative comments from onlookers.
People with disabilities hidden/laughed at, or avoided.	Sports group offering modified games, such as sit down volley ball, table soccer, and paired cricket (person A running, person B batting).	Clients more motivated to join in leisure occupations.

disabilities that we would need to address. Moreover, we found few guidelines to direct the preparation process within occupational therapy literature. The successful preparation strategies included attending meetings over the course of one week prior to our departure. We wanted to learn what we could about culturally appropriate dress, communication style, family customs, roles of men and women, taboo customs/beliefs/habits of the local people and attitudes to white people, from people familiar with the Solomon Islands. This also provided opportunity to practice the pidgin dialect, and come to understand the many differences between us and the local people. Cultural competency was further enhanced by preliminary tutorials and key readings provided by our supervisor and others, to facilitate reflection on our personal beliefs, attitudes, and values. In addition, on our arrival CBR workers and hospital based colleagues provided crucial insight into many aspects of the Solomon Island culture that might have taken us months to understand.

Interventions

Internet communications with experienced occupational therapists in Australia occurred regularly during the placement. As a result, our supervisor was able to suggest, direct, and provide feedback that led to the implementation of a group programme for children with cerebral palsy, as well as ideas for facilitating function for the child in the home. This advice usually came within a day of asking. Alternatively, other conditions presented a need for different expertise and locating a suitable clinician willing and able to offer appropriate advice often led to crucial delays. For example, burns and machete cuts were common due to the methods being used in the performance of daily occupations. In one instance, a girl required a splint for a burn to her hand. Finding a suitable advisor caused a two week delay in treatment inasmuch as the splint we made was unsuitable and the prescription of range of motion exercises was delayed. Things like this may have been avoided if we had more information about the type of conditions likely to require intervention prior to leaving.

Our physical presence in the hospital and in the communities gave us a realistic picture of what we could possibly achieve. Informal evaluation of the types, number, and adequacy of current programmes was addressed by talking with local people. After we discovered the cultural tendency to hide people with disabilities away from public view we investigated, and identified, the population groups missing out on service delivery. See Table 3.

Similarly, equipment could possibly have been organized and shipped in preparation. For instance, the local mobility aids (especially wheelchairs) and splinting materials were basic. Overall, we wanted to promote

autonomy and self sufficiency for the programme and workers in the Solomon Islands, and we did achieve this to some extent by modifying local items. Nonetheless, other items manufactured and easily available in Australia made an enormous difference. Some people with amputations for example, were given specially modified wheelchairs from Australia that had big tyres enabling them to navigate rough terrain. Overall the question of providing materials from Australia was a dilemma because it is contrary to the principles of CBR. Ultimately, we were guided by the philosophy of CBR which promotes self sufficiency for, and by, the local community. See Table 4.

Once the paucity of supplies and local funding options was revealed several aid agencies were approached for donations and the money was used for supplies. The indigenous occupational therapist collaborated and expanded our findings and efforts after she joined the team. Various organizational issues were also addressed. These included establishing a system for documentation, client transport, funding options, and staff accountability. See Table 5.

Discussion

This paper has described the experience of two Australian occupational therapy students on fieldwork placement in the Solomon Islands. The students planned interventions and coped with difficulties as they arose and thus achieved positive outcomes during their learning experience. Not having an occupational therapy supervisor at hand meant the students faced many challenges in trying to practice efficiently. Their local IBR physiotherapy supervisor provided valuable assistance by introducing contacts, interpreting, explaining cultural issues as they pertained to therapy, and setting up opportunities for practical experience. However, he had limited knowledge of the specifics of occupational therapy practice. Although the students were able to contact their Australian supervisor daily, they also

Table 4: Resources

Obstacles	Strategies	Outcomes
Limited access to technology.	Laptop computer taken to the Solomon Islands.	Reproducible outlines, handouts, application letters, and Occupational Therapy PowerPoint presentations.
Communication	Other staff interpreted, directions repeated, picture handouts created.	More effective communication.
Overwhelming need, disabilities, poverty, and unsanitary conditions.	Debriefed with fellow student; recorded personal feelings in a diary.	Self management - contained feelings of being overwhelmed / ineffective.
Absence of therapy tools.	Smooth sticks used to build up handles, bottles filled with stones to make a rattle.	Adaptive equipment and therapy items organised with little expense.
Other disciplines unaware of occupational therapy scope of practice.	In-service for IBR and CBR staff. Lecture to final year nursing students.	Staff more aware of occupational therapy knowledge base. CBR worker applied to study occupational therapy.

relied on each other for support. Coming from similar cultural backgrounds helped them to relate to each others needs.

Fransen (2005) identified important strategies to advance occupational therapy services within CBR. These included collecting and sharing examples of the work occupational

output had different levels of success. For instance, a small gift of a watch made a difference to time management but it was disappointing when documentation was not completed because there was no accountability. Training groups were always well attended, perhaps because the group dynamics were so powerful. For example, members of the sports group would encourage each

other to ignore negative comments from onlookers. Mentorship between old and new group members was a useful strategy to ensure ongoing group participation.

Given the local tendency to rely on the wantok system, a disabled person may assume it is family's duty to assist them with activities of daily living. Thus, relevant occupation based interventions met with mixed responses. Alternatively, engaging clients with disabilities in leisure occupations had much more impact on the Solomon Island locals. This may be because the singular sedentary activities found in Western cultures, such as TV and radio, are not available in the islands and so leisure occupations are commonly shared with others.

The lack of accurate information about the needs of clients with disabilities in the Solomon Islands prior to departure meant the students did not feel they were appropriately prepared. Those needs only became

evident when the students were faced with assessing client's needs. In addition, the students struggled to cope with the local attitude towards people with disabilities as the general community commonly responded by shunning or laughing at them.

Nonetheless, placements like this are worthwhile to both students, and the facilities that host them. They are a valuable opportunity for Western students to gain experiences they would unlikely be exposed to otherwise. Facilities that host student placements benefit from the students knowledge, skill, and enthusiasm, which are valuable commodities in the majority world. Working in collaboration with local people promotes self-esteem and determination, encourages ownership of programmes initiated, and thus the continuation of worthwhile projects.

Key messages:

- Occupational therapy services in the Pacific region benefit people with disabilities.
- Sharing knowledge of strategies used to meet the needs of people with disabilities living in adverse and under resourced communities as well as positive and negative outcomes is important.

Table 5: Improving work management skills

Obstacles	Strategies	Outcomes
Time management = 'bush time'.	CBR aides given watches.	Staff arrived on time.
Appointments missed due to 'bush time'.	Multiple clients scheduled am, noon, or pm only.	Attendance improved.
Walking as a means of transport.	4 wheel-drive borrowed from hosts.	More clients seen and equipment transported.
Large clientele, limited professional staff.	Various group programmes initiated.	Improved client contact. Group work enhanced therapy.
Poor writing skills to apply for financial and resource assistance.	Hard copy and electronic outline for letter writing to aid agencies provided.	Timber off-cuts to make equipment; petrol and the use of a school bus, and equipment for the visually impaired donated.
Developmental group for children with cerebral palsy poorly attended.	Group advertised via IBR and CBR programme, local radio, word of mouth.	12 children regularly attended the group.
Poor group work skills to run a developmental group for children with cerebral palsy.	A step-by-step guide written in simple English. Observation and mentoring of CBR aides.	CBR aides facilitated sessions independently and competently.
Lack of detail in documentation.	New client and family centred forms created.	Staff not interested in the extra work involved.

therapists are doing in CBR; mentorship from those working within CBR; development of process models that bridge the gap between occupational therapy theory and the realities of CBR practice; dissemination of information through publication; and research to improve occupational therapy's agency in CBR.

Outcomes

The students skill development initiatives were mainly aimed at the CBR aides. Although the effect of the students input was not formally reviewed, the students themselves thought documentation and group skills improved. The aides' ability to maintain the developed programmes was facilitated by providing them with resources, increased autonomy, and by inclusion in the latter stages of service development. Had they been involved in all stages of the programme development they may have gained more understanding and confidence. In the end, the new occupational therapist was provided with programme information for continued maintenance. In hindsight, it would have been more effective to include the occupational therapist from the beginning. In that way, she would have had increased ownership of the programme as it developed.

Strategies used to improve time management and thus work

- Collaboration with local people is essential for ongoing development of occupational therapy services in CBR.
- Professional communities in New Zealand and Australia could assist occupational therapy service development in under privileged communities by educating and supporting indigenous people through student placements.
- The WHO's CBR and IBR strategies require support and assistance from the worldwide occupational therapy profession to sustain health professionals, students and CBR workers.

Footnote:

At the completion of the placement, the CBR manager advertised three generic positions within the field of disability in Solomon Islands, in an Australia-wide Occupational Therapy newsletter. One of the CBR aides working at the time of this placement has now graduated from the local occupational therapy course.

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